TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
HEALTHCARE REHAB GROUP

**Respondent Name**
HARTFORD UNDERWRITERS INSURANCE

**MFDR Tracking Number**
M4-16-3441-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
JULY 14, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We have not received payment of any of these claims."

**Amount in Dispute:** $6,600.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The bills have been reconsidered an payment has been made. We have attached the EOBs and pay history."

**Response Submitted by:** Broadspire

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 15, 2016<br>March 16, 2016<br>March 17, 2016<br>March 29, 2016<br>March 31, 2016<br>April 5, 2016<br>April 6, 2016<br>April 7, 2016<br>April 12, 2016<br>April 14, 2016 | Chronic Pain Management Program – CPT Code 97799-CP-CA (44 Hours) | $6,600.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- A19-Upon further review. Additional payment is warranted.
- B79-Claims representative determined payment should be made.
- W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

**Issues**

Is the requestor entitled to additional reimbursement?

**Findings**

The requestor originally denied reimbursement for the chronic pain management services, CPT code 97799-CP-CA based upon the medical fee guideline. After the requestor sought dispute resolution, the respondent paid $5,500.00 based upon the medical fee guideline.

28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

> (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
>
> (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP-CA for 44 hours on the disputed dates of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour. $125.00 x 44 = $5,500.00. The carrier paid $5,500.00; therefore, additional reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is not due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 11/10/2016<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**